

LA PSICOLOGÍA DE HOY

**A DEFENSIVE “STAND-BY REACTION” AT CRITICAL MOMENTS
OF THE REPRODUCTIVE LIFE CYCLE****João Manel Rosado de Miranda Justo**

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<https://doi.org/10.17060/ijodaep.2014.n1.v4.604>*Fecha de Recepción: 15 Marzo 2014**Fecha de Admisión: 30 Marzo 2014***ABSTRACT**

Investigation about the psychological experiences of the reproductive life cycle showed that in critical moments special reactions may happen. These reactions seem to be defensive in nature, are set in motion in order to promote some kind of emotional protection and are performed in two opposite directions: a) a decreasing of the contact with aggressive impulses and b) an increasing of the use of rationalization and denial of frustrating situations. Examples of those rearrangements were observed at samples of: 1) pregnant women in obstetric high-risk consultation, 2) infertile couples waiting for infertility consultations and 3) pregnant women waiting for amniocentesis results. These data seem to be in accordance with the classical psychological points of view: a) gestation should be considered as a period of protection, b) during pregnancy a “primary maternal preoccupation” (Winnicott, 1958) emerges leading to the mobilization of all resources available for pregnant women and c) along gestational development psychological changes show how flexible maternal functioning may become. What was not expected is that in the absence of pregnancy, infertile couples should behave very similarly to what it is observed when pregnancy is in danger or when medical problems about the mother's or the baby's health arise in the horizon. Due to its “freezing” consequences upon emotional development we propose that this kind of reaction will be designated as “stand-by reaction”.

Keywords: pregnancy, psychological development, defense mechanisms, infertile couples, stand-by reaction.

COMUNICAÇÃO

Critical moments may require radical adaptations. When human reproduction is on the way possibly a good amount of the available resources will be mobilized to ensure the best conditions for the next generation to succeed. Unfortunately external and internal conditions may engender

A DEFENSIVE “STAND-BY REACTION” AT CRITICAL MOMENTS OF THE REPRODUCTIVE LIFE CYCLE

extremely stressful experiences. If so we should ask what is going to happen in the psychological functioning and in the health status of those people that go through the adventure of human reproduction.

In a first study about defense mechanisms in pregnant women (Justo, 1990) we were quite surprised about comparisons between gestational and non-gestational women. Pregnant women in obstetrical high-risk consultation showed very distinct patterns of defensive organization when compared with non-pregnant women and also when compared with pregnant women without obstetric risk. The fact is that responses to the Defense Mechanisms Inventory (Gleser & Ihilevich, 1986) provided by pregnant women attending an obstetric high-risk consultation (existence of a medical condition, suspicion of a medical condition or detection of a risk factor in a previous pregnancy) showed a clear decrement at the use of defenses related with the aggressive impulse. And this was observable not only for mechanisms enabling aggression to be executed but also for mechanisms related to the projection of aggression. At the same time we could see that other mechanisms were being overused. These were mechanisms that allow the rationalization or the denial of frustrating situations.

One can speculate about the meaning and usefulness of some defenses increment and the simultaneous decrement of some other defenses. Nevertheless, such effort should be done in the context of the knowledge about psychological adaptation to the steps of reproduction. Especially for women, psychological investigation suggested several important clues, namely that: a) during pregnancy, women's psychological development goes across three phases (Bibring, 1959; Bibring, Dwyer, Huntington & Valestein, 1961a; Bibring, Dwyer, Huntington & Valestein, 1961b; Colman & Colman, 1971); b) the lack of psychological development during gestation is possibly involved in adverse psychosomatic reactions (Justo, 2002); c) labor, delivery and birth may be affected by negative aspects of psychological functioning (Justo, 2005) and d) fetal and newborn behavior and development may be affected by negative emotional states experienced during pre, peri and early postnatal times (Weerth, van Hees, & Buitelaar, 2003; Van den Bergh, 1990). In this domain it is usually seen that, after pregnancy and delivery, the impossibility to achieve an healthy baby is experienced by newly mothers as the consequence of some personal failure or incompetence. So, guilt feelings are inevitable and the performance of maternal role becomes more difficult. Having this in mind, it is possible that, among users of obstetric high-risk consultation, the defensive shift observed is an attempt to avoid the self-blaming condition while it can be avoided.

How can a defensive adaptation reduce guilt feelings related with emerging obstetrical conditions or risk factors detection? A first ingredient in guilt appeasement is the lowering of the emotional level generated by the frustration of expectations. Rationalization and denial can allow for this reduction because: a) “convenient explanations are able to induce a more positive picture of the situation and b) denial is specifically dedicated to the reversal of the frustrating situation. A second ingredient is the need to decrease contact with any kind of aggressive emotion; probably, in the development of human beings, aggression and guilt are very early linked and, for that reason, it would become very difficult to decrease guilt without decreasing thoughts, fantasies and behaviors connected with the expression of aggressive impulses. At a first glance, the articulation of these two ingredients can be seen as a positive option but, unfortunately, in a second view, things may become not so good. From a psychometric point of view there is an obvious question of balance. Significant differences between pregnant women with and without obstetrical high risk implies that defensive organization is getting far from the expected; imbalance exists because, at the same time, we have too much use of some mechanisms and very few use of some other mechanisms. From an emotional point of view something very dangerous is on the way because, probably, this kind of defensive rearrangement prevents the contact between the self and emotions. Being so, it becomes clear that

the expected psychological development is not going to parallel biological development with negative consequences of all kinds.

Another surprise arrived with research about infertile couples. Since the middle of the twentieth century, infertility has been under scientific scrutiny in both medical and psychological terms. The huge development of medically assisted reproduction is quite visible in the multitude of technologies devoted to diagnosis and fertility induction. Nevertheless, after all medical investment, a percentage of more or less ten percent of infertility cases remains uncoupled with an objective medical factor. At the same time that medical progress was on the way, research with a psychosomatic background proposed several theories connected to the medical knowledge of this field. Unfortunately, psychosomatic theories seemed to fit very well for the understanding of clinical cases but, so far, didn't allow for the empirical linkage between psychological and fertility variables. Very interesting for this discussion is the fact that psychotherapy with infertile women does not only decreases psychological suffering (Domar, Clapp, Slawsby, Kessel, Orav & Freizinger, 2000b), as also significantly increases fertility in women undergoing medical treatment for infertility (Domar, Clapp, Slawsby, Kessel, Orav & Freizinger, 2000a) and, more than that, it also decreases NK cells' biochemical activity in infertile women (Hosaka, Matsubayashi, Sugiyama, Izumi & Makino, 2002). Probably, this parameter of psycho-neuro-immunological activity is the link between psychological variables and biomedical variables that for so long escaped to empirical research about infertility.

Now, the way infertile couples are approaching infertility treatment is particularly interesting for several reasons. One of those reasons has got to do with the amount of time those couples will underwent medical procedures until they reproduce or until they give up. In a route that can last for several years, psychological changes may become very negative and may have negative consequences upon reproductive success. Another reason is the psychological facet that has brought those couples into infertility consultation; the reason to look for this kind of medical specialty is never a happy one and in many couples is a step for psychological distress. So, if in the middle between those two courses we assess psychological functioning of infertile couples waiting for their first infertility consultation we are able to understand that a stand-by reaction is working underground (Justo, Melo & Ferreira, 2010). This defensive shift is very similar to the one found for pregnant women in obstetric high-risk; the use of defense mechanisms that allow the expression of aggression is lower than expected and the use of defense mechanisms that allow rationalization and denial of frustrating situations is heightened. What is astonishing is that infertile men do match very well the defensive profile of infertile women; after all, it is not only during pregnancy that men undergo psychological changes in order to be in tune with their female partner's reorganization.

In special conditions, pregnant women may have to undergo specific examinations related to their wellbeing as well as to their fetus' health. One of the most undesired situations is the performance of amniotic sac puncture for amniocentesis purposes. Besides the induction of negative emotional states due to a stressful anticipation of the amniotic liquid extraction, one must also reflect about what it means to be waiting for such critical results as those related with the genetic profile of a baby that is not born yet. If this is a problem, its weight is probably expanded because within certain conditions amniocentesis is considered to be mandatory; in this domain medical consensus is a reality when pregnant women have more than 35 years of age. Comparisons between pregnant women undergoing amniocentesis (due to maternal age) and pregnant women not performing amniocentesis were carried out by Leonardo (2007) in two different moments: a) for women that will undergo amniocentesis, before amniotic sac puncture (6-17 weeks of gestation) and after receiving clinical results (19-36 weeks of gestation) and b) for women not undergoing amniocentesis, in similar moments of pregnancy (8-18 and 20-30 weeks of gestation). These comparisons were done using the R-Interview (Stern, Robert-Tissot, Besson, Rusconi-Serpa, Muralt,

A DEFENSIVE “STAND-BY REACTION” AT CRITICAL MOMENTS OF THE REPRODUCTIVE LIFE CYCLE

Cramer, & Palacio, 1989). Pregnant women of the first group, before amniocentesis was performed, show a description of the baby much less rich than what is described by women that didn't undergo that diagnostic procedure. By the second moment of evaluation, differences were no longer significant. About the affective tone in the maternal description of the baby, it was observed that before puncture of the amniotic sac, women of the first group were much more non-positive than women of the second group. By the second moment of evaluation this difference was diminished. Very interestingly, before amniocentesis, mothers of the first group described their babies as less active and as more calm than what was described by mothers of the second group. Once more, by the second moment of evaluation, differences were mitigated. These data suggest that the stress connected with genetic pre-natal diagnostic is paralleled with a detachment from pregnancy evolution. So, as far as we can see, pregnant women in this situation tend to reduce the psychological investment of gestation and of its result and, after receiving diagnostic results, they seem able to reassume investment of gestation and possibly attachment to the baby.

Getting together data from pregnant women in obstetrical high-risk with data from infertile couples waiting for their first consultation and also with data from pregnant women under prenatal genetic diagnosis we can conclude in several ways. First, people adapt to stressful situations of the reproductive life cycle spontaneously. Second, this adaptation involves a kind of detachment/disinvestment of the reproductive situation with a proneness to avoid related aspects. Third, this psychological avoidance seems to result from defensive mechanisms working to prevent contact with aggressive impulses and to heighten rationalization and reversal of the situation. Fourth, probably, this induces two results: a) some relief of guilt feelings and b) some difficulty for emotional development to go on as would be expected. Fifth, under positive circumstances it is expected that, also spontaneously, this adaptation is reverted and psychological organization will become closer to what we can observe in people walking through the steps of reproduction without undergoing huge moments of stress. Sixth and finally, it seems possible that, in crucial moments of the reproductive cycle, men and women do walk through very similar psychological trajectories.

The concept of the stand-by reaction is useful not only to understand what is going when pregnant couples experience moments of crisis but also for two clinical purposes: 1) assessment and 2) intervention. If pregnancy is developing and stand-by reaction is leading the situation, clinical psychologists will notice that the patient speech shows an important characteristic; there is a lag between expected verbal contents and observed verbal contents. This means that, according to development characteristics of the three phases of gestation, ideas, worries, phantasies and other verbal communications should change as gestational age progress. In this sense, contents related to the working through of childhood relationships are expected during the first trimester but, probably, during the second trimester will be replaced by contents about the relationship with the baby's father. Later on, when gestational age is progressing into the grounds of the third trimester, possibly contents will become related to the baby and with its birth. Similarly, we expect that contents about other behavioral aspects will evolve according to gestational age namely feeding behavior, sexual behavior, dream contents, etc.

When speech contents do not match with gestational age probably we are observing consequences of defensive reactions that were activated by some objective or subjective circumstantial threatening questions. Trying to evaluate the gap between observed and expected contents, clinical psychologists may build an idea of how serious it is the delay in the psychological development of the pregnant women. Next to this evaluation is the need to calculate how much time do we have until pregnancy will reach its term. In the most difficult cases we understand that the delay is too big and the remaining time is too short. Even so, the experience of clinical psychologists performing consultation with obstetric high-risk patients is that it is possible to use very short periods of time to reach very important achievements at the domain of pregnant women psychological development.

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